STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005070	A. BUILDING: _____ B. WING _____	10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYM	1915 LAKE AVE PLYMOUTH, IN 46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00130501 Unsubstantiated: lack of sufficient evidence. Date: 10-09-13 Facility Number: 005070 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Saint Joseph Regional Medical Center-Plymouth is in compliance with 410 IAC 15-1.5-6, Nursing Service, 410 IAC 15-1.5-1, Dietetic services, and 410 IAC 15-1.5-5, Medical Staff, Indiana Hospital Licensure Rules. QA: claughlin 10/21/13	S 000		